

<i>SERFF Tracking Number:</i>	<i>GRTT-126762076</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United National Life Insurance Company of America</i>	<i>State Tracking Number:</i>	<i>46447</i>
<i>Company Tracking Number:</i>	<i>U1041N-AR</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement - Standard Plans 2010</i>	<i>Sub-TOI:</i>	<i>MS08I.011 Plan N 2010</i>
<i>Product Name:</i>	<i>Medicare Supplement Plan N</i>		
<i>Project Name/Number:</i>	<i>/U1041N-AR</i>		

## Filing at a Glance

Company: United National Life Insurance Company of America

Product Name: Medicare Supplement Plan N	SERFF Tr Num: GRTT-126762076	State: Arkansas
TOI: MS08I Individual Medicare Supplement - Standard Plans 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 46447

Sub-TOI: MS08I.011 Plan N 2010	Co Tr Num: U1041N-AR	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Stephanie Fowler
	Author: Joan Jannotta	Disposition Date: 08/26/2010
	Date Submitted: 08/10/2010	Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number: U1041N-AR	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: Filing concurrently.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/26/2010	Explanation for Other Group Market Type:
	State Status Changed: 08/26/2010
Deemer Date:	Created By: Joan Jannotta
Submitted By: Joan Jannotta	Corresponding Filing Tracking Number:
Filing Description:	
Re: Individual Medicare Supplement Insurance	
2010 Standardized Medicare Supplement Plan N	
Policy Form U1041N-AR	
Outline of Coverage UOC1041(N)	
Actuarial Memorandum and Rates	

NAIC #92703 903



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 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.011 Plan N 2010  
 Standard Plans 2010  
 Product Name: Medicare Supplement Plan N  
 Project Name/Number: /U1041N-AR

## Company and Contact

### Filing Contact Information

Joan Jannotta, jjannotta@gtlic.com  
 1275 Milwaukee Ave. 847-904-5730 [Phone]  
 Glenview, IL 60025 847-699-0093 [FAX]

### Filing Company Information

United National Life Insurance Company of America CoCode: 92703 State of Domicile: Illinois  
 1275 Milwaukee Ave. Group Code: 903  
 Glenview, IL 60025 Group Name: Company Type:  
 (847) 803-5252 ext. [Phone] FEIN Number: 37-1095206  
 State ID Number:

## Filing Fees

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? Yes  
 Fee Explanation: 1 rate = \$50  
 1 form = \$50

Total \$100

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
United National Life Insurance Company of America	\$100.00	08/10/2010	38644029

<i>SERFF Tracking Number:</i>	<i>GRTT-126762076</i>	<i>State:</i>	<i>Arkansas</i>
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## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Stephanie Fowler	08/26/2010	08/26/2010

SERFF Tracking Number:	GRTT-126762076	State:	Arkansas
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## Disposition

Disposition Date: 08/26/2010

Implementation Date:

Status: Approved-Closed

Comment: This approval is subject to the following:

- Increases will not be given more frequently than once in a twelve-month period;
- Both the insured and agent shall be notified by the insurer of its intention to increase the rate for renewal not less than thirty (30) days prior to the effective date of the renewal.

Rate data does NOT apply to filing.

SERFF Tracking Number: GRTT-126762076 State: Arkansas

Filing Company: United National Life Insurance Company of America State Tracking Number: 46447

Company Tracking Number: U1041N-AR

TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 Sub-TOI: MS08I.011 Plan N 2010

Product Name: Medicare Supplement Plan N

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Accepted for Informational Purposes	Yes
Supporting Document	Application	Accepted for Informational Purposes	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Form	Policy	Approved	Yes
Form	Outline	Approved	Yes
Rate	Rates	Approved	Yes

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## Form Schedule

### Lead Form Number: U1041N-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 08/26/2010	U1041N-AR	Policy/Cont ract/Fratern al Certificate	Policy	Initial		46.960	U1041N-AR.pdf
Approved 08/26/2010	UOC1041(N)	Outline of Coverage	Outline	Initial			UOC1041(N) Chart (10).pdf UOC1041(N).pdf

## UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA

A Stock Company - P. O. Box 1154 - Glenview, Illinois 60025-1154 - (847) 803-5252

We, **United National Life Insurance Company of America**, promise to pay You, the benefits described in this Policy for loss which results from Injury or Sickness while this Policy is in force. All benefits are subject to its definitions, provisions, limitations and exceptions. We make this promise in consideration of the application for this Policy and the payment of the Premium. Your application is attached to and made a part of this Policy.

**Important Notice About Statements in the Application** – Please read the copy of the application which is a part of this Policy. Check to see if any medical history requested has been left out. Write Us if any information shown isn't right or complete. We issued this Policy on the basis that the answers to all the questions are right and complete. Any wrong or left out statements could cause an otherwise valid claim to be denied.

**Right To Examine Policy For 30 Days** – If You are not satisfied with this Policy, You may return it to Us within 30 days after You get it. You may return it to Us by mail or to the agent who sold it. Then We will refund to You any premium paid and this Policy will be void.

**Effective Date** – This Policy begins at 12:01 a.m. Standard Time where You live on the Issue Date shown in the Schedule. It ends, subject to the grace period, at 12:01 a.m. on the date any renewal premium is due.

**Guaranteed Renewable for Life** - You may keep this Policy in force during Your entire lifetime by paying premiums when due or within the grace period. We can't cancel or refuse to renew this Policy because of a change in Your health. This Policy may be cancelled for nonpayment of premium or material misrepresentation in Your application.

**Renewal Premium** – We will change the premium rates for this Policy, but only if they are changed for all policies like Yours in Your state on a class basis. The change may be due to change in Your benefits or a new table or rates. As Your Policy benefits are tied to Medicare's benefits, Your Policy benefits and premiums are expected to change each year due to a change in Medicare's benefits. We will tell You in advance of any change in premium.

**Notice to Buyer:** This Policy may not cover all of Your medical expenses.

Signed at United National Life Insurance Company of America in Glenview, Illinois by



President



Secretary

Licensed Resident Agent (If Required): \_\_\_\_\_

## MEDICARE SUPPLEMENT INSURANCE POLICY – PLAN N

This Policy is a legal contract between You and Us.



**Read Your Policy carefully.**

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## SUSPENSION OF BENEFITS

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If You become entitled to medical assistance from Medicaid and, within ninety (90) days after entitlement, notify us and request a suspension, we'll suspend Your benefits and premiums for the period of Medicaid eligibility, not to exceed twenty-four (24) months (suspension period).

If You are eligible for, and have purchased this Policy by reason of disability and You later become covered by an employer or union-based group health plan, the benefits and premiums under Your Policy can be suspended, if requested, while You are covered under the employer or union-based group health plan.

Suspension of policy benefits and premiums will begin from the date of Your Medicaid eligibility or the effective date of Your employer or union-based group health plan. When We get the timely notice, to the extent permitted by applicable law or regulation, We'll refund any premium paid covering a period beyond the date of eligibility for Medicaid or effective date of Your employer or union-based group health plan. Any refund will be subject to adjustment for paid claims.

If you lose entitlement to Medicaid benefits or Your employer or union-based group health plan during the suspension period and notify Us so within ninety (90) days, then, effective the date Medicaid entitlement or employer or union-based group health plan terminated, We'll (a) automatically reinstitute this Medicare Supplement coverage or substantially equivalent coverage which was in effect before the date of suspension, upon payment of the required premium; and (b) charge a premium at least as favorable as if the coverage had not been suspended.

## DEFINITIONS

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**Actual Charge** means the Actual Charge made by the provider for services or supplies in the absence of insurance, but not to exceed the maximum actual allowable charge determined by Medicare for non-participating providers.

**Benefit Period** means the time used to measure in-hospital benefits for expenses covered by Medicare. A Benefit Period begins after the effective date of coverage with the first day You receive Medicare covered services in a Hospital. The date it ends is determined by Medicare.

**Coinsurance** means an amount You may be required to pay as your share of the costs for Medicare Eligible services, after You pay any plan deductibles. Coinsurance is usually a percentage.

**Copayment** means an amount You may be required to pay as Your share of the cost for a Medicare Eligible medical service or supply, like a doctor's visit or a prescription. A copayment is usually a set amount, rather than a percentage.

**Doctor** means a legally qualified practitioner of the healing arts, other than You or a Family Member, approved by Medicare to treat the type of condition for which claim is made.

**Family Member** means a person who is related to You in any of the following ways: spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild). A Family Member includes an individual who normally lives in Your household.

**Hospice Care** means a program of palliative care that provides for the physical, emotional, and spiritual care needs of a terminally ill patient and his or her family. The goal of such care is to achieve the highest quality of life as defined by the patient and his or her family through the relief of suffering and control of symptoms.

**Hospital** means a Hospital that is either approved for payment of Medicare benefits or could receive such approval if so requested.

**Injury** means an accidental bodily Injury which occurs while this Policy is in force and causing loss which commences while this Policy is in force.

## Definitions (continued)

**Medicare** means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

**Medicare Eligible Expenses** means expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as medically necessary and reasonable by Medicare. These expenses may or may not be fully covered by Medicare.

**Medicare Part A Deductible** means the initial fixed amount Medicare does not pay for Part A inpatient Hospital services during a Benefit Period. This amount is determined by Medicare.

**Medicare Part B Annual Deductible** means the initial fixed amount Medicare does not pay under Part B for expenses covered by Medicare in each Calendar Year. This amount is determined by Medicare.

**Policy or Contract** means this legal agreement between You and Us.

**Respite Care** means professional care given to You in order to temporarily relieve unpaid Informal Caregivers.

**Sickness** means an illness or disease of an insured person which first manifests itself after the effective date of coverage and causes loss which commences while this Policy is in force.

**Skilled Nursing Copayment** means the fixed amount per day Medicare does not pay during a Medicare covered Skilled Nursing stay. The amount of Skilled Nursing Copayment is set each year by Medicare.

**You or Your** means the person who is insured under this Policy and named in the Schedule.

**We, Our or Us** means United National Life Insurance Company of America.

## BENEFIT PROVISIONS

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### MEDICARE SUPPLEMENT BENEFITS

We'll pay benefits for covered Medicare Eligible Expenses You incur due to Injury or Sickness. Covered expenses and Policy benefits and limits are explained below. To be covered, the Medicare Eligible Expense must be incurred while coverage under this Policy is in force.

Any claim for a continuous loss that begins while this Policy is in force won't be affected by the ending of this Policy. But, benefits for such continuous loss may be conditioned upon Your continuous total disability, and are limited to the duration of the Medicare Benefit Period, if any, or the maximum benefits payable.

We'll pay benefits listed below as though You have coverage under both Medicare hospital and medical insurance, and as though Medicare paid its share of the covered expense. We won't impose any limitations on benefits that are more restrictive than Medicare's limitations and restrictions.

**Explanation of Medicare Benefits Form** - before We can pay any benefits for expenses covered under Medicare Part B, You or Your health care provider must file a claim with Medicare. We must then get the Explanation of Medicare Benefits form. It's a form sent by Medicare's Benefit Department. It shows the Medicare Eligible Expenses.

We'll pay as follows:

#### Basic Benefits

1. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare Benefit Period;
2. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

### **Basic Benefits (continued)**

3. Upon exhaustion of the Medicare Hospital inpatient coverage, including the lifetime reserve days, coverage of one hundred percent (100%) of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept Our payment in full and may not bill You for any balance;
4. Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;
5. Coverage for the Coinsurance amount, or in the case of Hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare Eligible Expenses under Part B regardless of Hospital confinement, subject to the Medicare Part B deductible;
6. Coverage for each covered provider office visit, including visits to medical specialists, subject to the provider office visit copayment of the lesser of the amount shown on the Schedule page or the Medicare Part B copayment amount, subject to the Medicare Part B deductible;
7. Coverage for each covered emergency room visit subject to an emergency room visit copayment of the lesser of the amount shown on the Schedule page or the Medicare Part B copayment amount, subject to the Medicare Part B deductible. The emergency room visit copayment shall be waived if You are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense;
8. Hospice Care: Coverage of the cost sharing for all Part A Medicare eligible Hospice Care and Respite Care expenses.

### **Additional Benefits**

1. Medicare Part A Deductible: Coverage for one hundred percent (100%) of the Medicare Part A inpatient Hospital deductible amount per Benefit Period.
2. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare Benefit Period for post-Hospital Skilled Nursing facility care eligible under Medicare Part A.
3. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare Eligible Expenses for medically necessary emergency Hospital, Doctor, and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars (\$250) and a lifetime maximum benefit of fifty thousand dollars (\$50,000).

For purposes of this benefit, "emergency care" shall mean care needed immediately because of an Injury or an illness of sudden and unexpected onset.

Before Part A and Part B Policy benefits are payable, benefits must be payable under Part A and Part B of Medicare for its part of the expenses.

### **Benefit and Premium Change**

The risk We assumed on this Policy's Issue Date was based on Medicare's benefit structure at that time. Medicare benefits change from time to time. When Medicare changes its deductible or co-payment amounts, or limits under its benefit structure that was in effect on the Effective Date, We'll change benefits to handle such changes.

Medicare's benefit structure may change to the extent that the nature of the risk We assumed at issue changes. If it does, We may have to change this Policy's coverage. We will make such a change by adding an endorsement or new schedule page to the Policy or both. Before We make any such change, We'll get approval from the government agency in the state that regulates Your insurance. Until the effective date of any coverage change, benefits will be based upon the risk we assumed on this Policy's Issue Date.

Any premium change needed because of such a benefit or structure change may be made only after We give You the advance notice Your state requires.

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## **LIMITATIONS AND EXCLUSIONS**

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### **Exclusions**

This Policy does not cover or consider for payment any service or supply, or any portion of a service or supply that is not a Medicare Eligible Expense, nor will this Policy duplicate any benefit paid by Medicare.

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## **UNIFORM PROVISIONS**

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### **Entire Contract; Changes:**

This Policy, a copy of the application, and any attached papers, is the Entire Contract between You and Us. No change in this Policy will be effective until approved by two of Our executive officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

### **Time Limit On Certain Defenses**

After 2 years from the Effective Date only fraudulent misstatements in the application may be used to void this Policy or deny any claims for loss which starts after the 2 year period.

### **Grace Period**

This policy has a 31 day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the Grace Period, this Policy will stay in force. If a premium is not paid during the Grace Period, this Policy will terminate as of the due date of the unpaid premium. If You send written notice to Us that You are not renewing Your coverage, then the Grace Period will not apply after the date the non-renewal is to be effective.

### **Reinstatement**

If the premium isn't paid before the Grace Period ends, this Policy will lapse. Later acceptance of premium by Us or by Your agent without requiring an application for reinstatement, will reinstate this Policy.

If You were asked to complete an application, You'll be given a conditional receipt for the premium. If the application is approved, this Policy will be reinstated as of the approval date. Lacking such approval, this Policy will be reinstated on the 45<sup>th</sup> day after the date of the conditional receipt unless We previously notified You, in writing, of Our disapproval.

The reinstated Policy will cover loss which results from an Injury sustained after the date of reinstatement or sickness that starts after such date. In all other aspects Your rights and Our rights will remain the same, subject to any provisions noted on or attached to the reinstated Policy.

### **Premium Refund at Death**

We will refund within 30 days after we receive proof of Your death, that portion of the premium paid covering the period beyond the month of death.

### **Notice of Claim**

You must give Us written notice of claim within 20 days after a covered loss starts or as soon as possible. The notice can be given to Us at Our home office in Glenview, Illinois, or to Your agent. Notice should include Your name and Policy number.

### **Claim Forms**

When we get notice of claim, We'll send You forms for filing proof of loss. If these forms aren't given to You within 15 days, You'll meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss. We must get this statement within the time limit stated in the Proofs of Loss section.

**Proofs of Loss**

Written proof of loss must be given to Us within ninety (90) days of such loss. If it was not reasonably possible to give Us written proof in the time required, we won't reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof required must be given no later than one (1) year from the time specified unless You were legally unable to act.

**Time of Payment of Claims**

We will pay all benefits then due under this Policy as soon as we get proper written proof of loss.

**Payment of Claims**

We will pay the benefits to You or to the health care provider. Any unassigned benefits due and unpaid at Your death may be paid, at our choice, either to Your estate or beneficiary.

If benefits are payable to Your estate or Your beneficiary who can't give valid release, We may pay up to \$1,000 to anyone related to You by blood or marriage, whom We consider to be entitled to the benefits. We'll be discharged to the extent of any such payment made in good faith.

**Physical Examinations**

We, at Our own expense, have the right to have You examined as often as reasonably necessary while a claim is pending.

**Legal Action**

A legal action may not be brought to recover on this Policy within sixty (60) days after written proof of loss has been given as required by this Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

**Other Insurance With Us**

You may have only one Policy like this one with us. If through error, We issue more than one like Policy to You, only one Policy chosen by You, or if necessary Your beneficiary or estate, will stay in force. We'll return the money You paid for the other Policies.

**Conformity With State Statutes**

Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the state in which You live on that date is amended to conform to the minimum requirements of such laws.

**UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA**

**A Stock Company**

**P.O. Box 1154**

**Glenview, Illinois 60025-1154**

**(847) 803-5252**

**MEDICARE SUPPLEMENT  
INSURANCE**

### Benefit Chart of Medicare Supplement Plans Sold For Effective Dates On or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan “A” available. Some plans may not be available in your state.

[Plans E, H, I and J are no longer available for sale.]

#### Basic Benefits:

- \* **Hospitalization** - Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- \* **Medical Expenses** - Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- \* **Blood** – First three pints of blood each year.
- \* **Hospice** – Part A coinsurance

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit \$[4,620]; paid at 100% after limit reached.	Out-of-pocket limit \$[2,310]; paid at 100% after limit reached.		

- \* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year [\$2,000] deductible. Benefits from high deductible Plans F and J will not begin until out-of-pocket expenses exceed [\$2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare Deductibles for Part A and Part B, but do not include the plan’s separate foreign travel emergency deductible.



### **PREMIUM INFORMATION**

We, United National Life Insurance Company of America, can only raise your premium if we raise the premium for all policies like yours in this State on a class basis.

### **DISCLOSURES**

Use this outline to compare benefits and premium among policies.

[This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010 have different benefits and premiums. Plans E, H, I and J are no longer available for sale.]

### **READ YOUR POLICY VERY CAREFULLY**

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

### **RIGHT TO RETURN POLICY**

If you find that you are not satisfied with your policy, you may return it to P. O. Box 1154, Glenview, Illinois 60025-1154. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

### **POLICY REPLACEMENT**

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

### **NOTICE**

This policy may not fully cover all of your medical costs.

**Neither United National Life Insurance Company of America nor its agents are connected with Medicare.**

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult *Medicare and You* for more details.

### **COMPLETE ANSWERS ARE VERY IMPORTANT**

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

## PLAN A

### MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$0 \$[275] a day  \$[550] a day  100% of Medicare eligible expenses  \$0	\$[1,100] (Part A Deductible) \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 \$0 \$0	\$0 Up to \$[137.50] a day All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN A

### MEDICARE (PART B )-MEDICAL SERVICES-PER CALENDAR YEAR

\* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      \$0  Generally 80%	      \$0  Generally 20%	      \$[155] (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	 \$0 \$0 80%	 All costs \$0 20%	 \$0 \$[155] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

## PARTS A & B

<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED SERVICES</b> -Medically necessary skilled care services and medical supplies -Durable medical equipment First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      100%  \$0  80%	      \$0  \$0  20%	      \$0  \$[155] (Part B Deductible)  \$0
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## PLAN D

### MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

- \* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$[1,100] (Part A Deductible) \$[275] a day  \$[550] a day  100% of Medicare eligible expenses  \$0	\$0 \$0  \$0  \$0**  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-ayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

- \*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN D

### MEDICARE (PART B) – MEDICAL SERVICES-PER CALENDAR YEAR

\* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	      \$0  Generally 80%	      \$0  Generally 20%	      \$[155] (Part B Deductible) \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	\$0	All costs
<b>BLOOD</b> First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$[155] (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN D  
PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> <b>MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment			
First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b> <b>NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## PLAN F or HIGH DEDUCTIBLE PLAN F

### MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not receive skilled care in any other facility for 60 days in a row.

[\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,000] DEDUCTIBLE**] PLAN PAYS	[IN ADDITION TO \$[2,000] DEDUCTIBLE** ] YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$[1,100] (Part A Deductible) \$[275] a day  \$[550] a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$0  \$0***  All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co-ayment/coinsurance for outpatient drugs and inpatient respite care	Medicare co-payment/ coinsurance	\$0

(continued)

\*\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN F or HIGH DEDUCTIBLE PLAN F

### MEDICARE (PART B) – MEDICAL SERVICES-PER CALENDAR YEAR

\* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

[\*\* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$[2,000] deductible. Benefits from the high deductible plan F will not begin until out-of-pocket expenses are \$[2,000]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

SERVICES	MEDICARE PAYS	[AFTER YOU PAY \$[2,000] DEDUCTIBLE **] PLAN PAYS	[IN ADDITION TO \$[2,000] DEDUCTIBLE **] YOU PAY
<b>MEDICAL EXPENSES</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	          \$0  Generally 80%	          \$[155] (Part B Deductible)  Generally 20%	          \$0  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$[155] (Part B Deductible)  20%	\$0  \$0  \$0
<b>CLINICAL LABORATORY  SERVICES – TESTS FOR  DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)



**PLAN F or HIGH DEDUCTIBLE PLAN F**

**PARTS A & B**

<b>SERVICES</b>	<b>MEDICARE PAYS</b>	<b>[AFTER YOU PAY \$[2,000] DEDUCTIBLE **] PLAN PAYS</b>	<b>[IN ADDITION TO \$[2,000] DEDUCTIBLE **] YOU PAY</b>
<b>HOME HEALTH CARE MEDICARE APPROVED SERVICES</b>			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment First \$[155] of Medicare Approved Amounts*	\$0	\$[155] (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL NOT COVERED BY MEDICARE</b>			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar Year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## PLAN G

### MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days  -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day  All but \$[550] a day  \$0  \$0	\$[1,100] (Part A Deductible) \$[275] a day  \$[550] a day  100% of Medicare eligible expenses \$0	\$0 \$0  \$0  \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited co/payment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN G

### MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

\* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES</b> IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	       \$0  Generally 80%	       \$0  Generally 20%	       \$[155] (Part B Deductible)  \$0
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	0%	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[155] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0  \$0  80%	All costs  \$0  20%	\$0  \$[155] (Part B Deductible)  \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN G**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b> NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

## PLAN N

### MEDICARE (PART A) – HOSPITAL SERVICES-PER BENEFIT PERIOD

\* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOSPITALIZATION*</b> Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61 <sup>st</sup> thru 90 <sup>th</sup> day 91 <sup>st</sup> day and after: -While using 60 lifetime reserve days -Once lifetime reserve days are used: -Additional 365 days -Beyond the additional 365 days	All but \$[1,100] All but \$[275] a day All but \$[550] a day \$0 \$0	\$[1,100] (Part A Deductible) \$[275] a day \$[550] a day 100% of Medicare eligible expenses \$0	\$0 \$0 \$0 \$0** All costs
<b>SKILLED NURSING FACILITY CARE*</b> You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital First 20 days 21 <sup>st</sup> thru 100 <sup>th</sup> day 101 <sup>st</sup> day and after	All approved amounts All but \$[137.50] a day \$0	\$0 Up to \$[137.50] a day \$0	\$0 \$0 All costs
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for out-patient drugs and inpatient respite care	Medicare co-payment/coinsurance	\$0

\*\* **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

## PLAN N

### MEDICARE (PART B)-MEDICAL SERVICES-PER CALENDAR YEAR

\* Once you have been billed \$[155] of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT</b> , such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment. First \$[155] of Medicare Approved Amounts* Remainder of Medicare Approved Amounts	\$0  Generally 80%	\$0  Balance, other than up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$[155] (Part B Deductible)  Up to [\$20] per office visit and up to [\$50] per emergency room visit. The copayment of up to [\$50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
<b>Part B Excess Charges</b> (Above Medicare Approved Amounts)	0%	0%	All costs
<b>BLOOD</b> First 3 pints Next \$[155] of Medicare Approved Amounts*  Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$[155] (Part B Deductible) \$0
<b>CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES</b>	100%	\$0	\$0

(continued)

**PLAN N**  
**PARTS A & B**

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES			
-Medically necessary skilled care services and medical supplies	100%	\$0	\$0
-Durable medical equipment First \$[155] of Medicare Approved Amounts*	\$0	\$0	\$[155] (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

**OTHER BENEFITS-NOT COVERED BY MEDICARE**

<b>FOREIGN TRAVEL</b> NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First \$250 each calendar year	\$0	\$0	\$250
Remainder of Charges	\$0	80% to a lifetime maximum benefit of \$50,000	20% and amounts over the \$50,000 lifetime maximum

SERFF Tracking Number:	GRTT-126762076	State:	Arkansas
Filing Company:	United National Life Insurance Company of America	State Tracking Number:	46447
Company Tracking Number:	U1041N-AR		
TOI:	MS08I Individual Medicare Supplement - Standard Plans 2010	Sub-TOI:	MS08I.011 Plan N 2010
Product Name:	Medicare Supplement Plan N		
Project Name/Number:	/U1041N-AR		

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action: Action:*	Rate Action Information:	Attachments
Approved 08/26/2010	Rates	U1041N-AR	New		AR Plan N Rates.pdf



**United National Life Insurance Company**  
**Standardized Medicare Supplement Premium Rates**  
 Annual Rates - Effective 7/1/2010

**ARKANSAS**

	Plan N - Annual Rates			Plan N - Monthly Rates	
Age	Preferred	Standard		Preferred	Standard
All Ages	1,302.00	1,447.20		108.50	120.60

A discount factor of 0.93 is applied for married applicants

Zip Codes

720-722

716-719, 723-729

Area Factors

0.93

0.80

<i>SERFF Tracking Number:</i>	<i>GRTT-126762076</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>United National Life Insurance Company of America</i>	<i>State Tracking Number:</i>	<i>46447</i>
<i>Company Tracking Number:</i>	<i>U1041N-AR</i>		
<i>TOI:</i>	<i>MS08I Individual Medicare Supplement - Standard Plans 2010</i>	<i>Sub-TOI:</i>	<i>MS08I.011 Plan N 2010</i>
<i>Product Name:</i>	<i>Medicare Supplement Plan N</i>		
<i>Project Name/Number:</i>	<i>/U1041N-AR</i>		

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Accepted for Informational Purposes	08/26/2010
<b>Comments:</b>			
<b>Attachment:</b>	readcert Plan N.pdf		
		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Application	Accepted for Informational Purposes	08/26/2010
<b>Comments:</b>	Application UAPPH7-08, approved 10/10/09.		
		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Outline of Coverage	Approved	08/26/2010
<b>Comments:</b>	Please see the forms tab.		

## CERTIFICATE OF READABILITY

Form Number(s): U1041N-AR

Flesch Test Score(s): 46.96

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA



\_\_\_\_\_  
Arthur G Fess  
President

Date 8/10/10